2005 Comprehensive Case Review Report
Prepared by BMCW Program Evaluation Managers

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Bureau of Milwaukee Child Welfare
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Contents

2005 Comprehensive Case Review Report

Introduction

This is the Comprehensive Case Review Report of the major program areas of the Bureau of Milwaukee Child Welfare (BMCW). It is the most recent in a series of reviews conducted by the Program Evaluation Managers (PEMs) to:

- assess the program operations of the Bureau;
- identify strengths, areas of progress and those needing improvement;
- inform management about trends, and
- provide recommendations regarding practice, training or changes in service provision.

This is the third Comprehensive Review required by the Settlement Agreement of the *Jeanine B. v. Doyle* lawsuit approved by U.S. District Court Judge Rudolph T. Randa in December 2002.

The 2005 Comprehensive Review is designed to evaluate the quality of BMCW programs. The more quantitative review of the Bureau is found in the *2005 Period 2 Settlement Report*, which provides statistical information required by the Settlement Agreement, while this report concentrates on the quality of casework management and services provided to the BMCW children and families.

Review Protocol

The review protocol is a modified version of the review process used in the Federal Child and Family Services Review (CFSR). It includes reviews of case records and interviews with key participants of the case to assess the quality of casework being delivered by the Bureau's major programs. Another major component of the review is the diversity of the review team, which included PEMs, BMCW Site Managers, other State staff and community volunteers. Community participants included representatives from 11 organizations from the Milwaukee area and one person from state government in Madison. The community volunteers were especially helpful because of the varied experience and viewpoints they brought to the review.

Nature of Review

The evaluation system used was a series of statements arranged in a hierarchy of achievements or standards, designed specifically for the different Bureau

programs. This specific format, called a rubric, allows the performance of the program or agency to be divided into essential traits that can then be evaluated separately. The rubric allowed the reviewers to rate the quality of each specific area of performance with a score of 2, 1 or 0, according to the following:

- 2 = practice standards were fully met,
- 1 = the practice standards were largely unmet or met only minimally, and
- 0 = practice standards were not met or important considerations were ignored.

In some situations, the reviewers had the option of assigning a score of NA (not applicable) if the measure did not apply to a particular area in the case. The review instrument required the evaluators to assign scores for each of the key areas to be measured for the program and to provide comments explaining why the rating was given. A more descriptive explanation of the training and scoring protocol can be found in *Appendix A.*

The record review primarily used the Wisconsin Statewide Automated Child Welfare Information System (WiSACWIS) to document case narratives, demographic information and financial information on the families served by the Bureau. The physical file was also available to reviewers. This file contains collateral reports, such as copies of medical or psychological evaluations, that are not found in WiSACWIS.

Interviews were conducted with parents, children, case managers, foster parents, service providers and other key individuals in each case to gain a clearer picture of the quality of case management. As with the federal Child and Family Services Review (CFSR), programs were not penalized for failing to document information that could be verified through interviews or other means.

Case Sample and Scope: Time Frame July 1, 2005 to December 31, 2005

While the specifics of the case sample chosen for each program will be discussed under its program heading, there were some commonalties among the samples. The focus of the review was on the third and fourth quarter of 2005. Feedback from the interviews from the 2004 review indicated that direct services staff, supervisors, foster parents and family members had difficulty remembering events and situations that may have occurred during arbitrary time frames in the past. As a result, the effective time frame for each of these reviews was the period of July 1, 2005 up to the date of the review itself. Although this meant that some programs were under scrutiny for a longer period of time than others, focusing on the recent past and present eliminated the problem of interviewees confusing time frames or having to remember far in the past. It also was meant to ensure that the case participants identified for interviews, generally the current assigned staff and

foster provider, would have relevant information regarding the time frame being considered.

Building on the work done for the 2003 and 2004 Comprehensive Reviews, the reviewers' intent was to mirror the protocol used by federal reviewers in the Child and Family Service Reviews and to select cases for review where family members and other case participants would be available for interviews. To facilitate this process, lists of cases meeting review criteria were selected in advance and forwarded to the managers of the program to be reviewed. These lists included both a preferred list and several additional cases to serve as the over sample in the event that the original cases could not be used. The program staff members were responsible for contacting case participants regarding their availability for interviews. In the event that case participants from the basic list were unavailable or uncooperative, cases from the over sample could be selected instead, with the understanding that the program staff provide the Bureau with an explanation for any unused cases. In all programs except for Intake, there was an expectation that a client and a case manager involved with the case would be available for an interview.

The review was designed to require the management of the different programs to make at least one parent or family member from each case available to be interviewed. As in past PEM reviews, interpreters were made available but were not needed for any of the cases selected.

It is understood that the requirement of parent interviews may have had an effect on the review beyond that of increasing the amount of information about specific cases. For example, by including only cases where at least one parent is involved in services and nominally cooperative with Bureau efforts, there is no opportunity to examine casework with families who refuse to participate or to evaluate efforts to locate parents whose whereabouts are unknown. It is also possible that the cases thus referred were disproportionately those that have already benefited from good casework.

In spite of efforts to make interviews part of each case review, as in past reviews, the review team was unable to conduct interviews on all cases. Parents were under no obligation to participate. In many cases people who had agreed to interviews failed to keep scheduled appointments or be available by telephone. Some case managers did not appear for all the interviews, although an increased use of telephone interviews allowed greater participation in some programs.

As with prior Comprehensive Reviews, this selection process does not assure that the sample chosen is statistically representative of all cases the Bureau serves. However, as the purpose of this review is qualitative rather than quantitative, the intent was more to determine what kinds of issues and concerns are present in the casework being done by the Bureau and its programs, even if it is not possible

from this review design to determine how widespread or prevalent those problems are.

The numbers of cases reviewed per program were as follows:

Screened-in Intakes: 50
Screened-out Intakes: 10
Initial Assessment: 50
Independent Investigations: 25
Ongoing Case Management: 50
Adoption: 25
Safety Services: 25
Out-of-Home Care: 27

For the programs with more than one service site, the sample was modified so that each site contributed the same number of cases.

Evaluators

The review teams consisted of Program Evaluation Managers and the five site managers from the Bureau of Milwaukee Child Welfare. Site managers were not involved with reviewing cases in which they had supervisory responsibilities. Other State staff, such as Fiscal Program Evaluation Managers and other BMCW staff also participated. In addition, the Bureau solicited professionals from diverse agencies, institutions, and advocacy groups familiar with the work of the Bureau to volunteer to be community reviewers, as had been done for the 2004 Comprehensive Review.

This year, community participants included representatives from Children's Hospital of Wisconsin, the Milwaukee Public Schools, Milwaukee Health Department, District Attorney's Office at Children's Court, Milwaukee Mental Health Association, State Department of Health and Family Services-Division of Health Care Finance, Saint Aemilian-Lakeside, Task Force on Family Violence, Social Development Commission, COA Youth and Family Centers, In Their Best Interests, Neighborhood House and Court Appointed Special Advocates (CASA).

Structure of the Report

The findings of each program area are presented individually within this report. Each section's content is limited to the program reviewed and to the cases specifically chosen. If the data suggest that differences between service sites can be ascertained based on the review information, these differences are noted. However, in many situations the sites were similar enough in their ratings and practices to make site-based reporting unhelpful in analyzing the results.

Each section includes a brief description of the program reviewed, a discussion of the areas focused on during the review, comparisons with findings from the 2003 and 2004 Comprehensive Reviews, when applicable, and recommendations for further improvement. Whenever possible, separate headings are given as part of the findings to highlight the strengths and concerns identified during the review. However, there are some areas where the observations do not readily lend themselves to one category or another.

Intake Program

Program Description

Intake is the program responsible for receiving referrals of child abuse and neglect from the Milwaukee County community, entering the referral into the Bureau's information system, making decisions whether to refer the allegations for further investigation and assigning a response time. Intake staff are limited to two principal sources of information: the person making the referral and the Bureau's internal records of past referrals and cases. It is, therefore, understood that the documentation found in cases at Intake may be less specific and detailed than the information from other programs. This information, however, must contain references to specific topics that are outlined in the *State of Wisconsin's Child Protective Service Investigative Standards* (1994). These standards specify the decisions and supporting rationale that must be documented for different types of allegations and different classes of referrals. The Bureau of Milwaukee Child Welfare utilizes certified social workers as Intake staff, who have the expertise to gather this information from the reporter. This information must be as complete as possible to ensure accurate screening decisions.

Referrals received by Intake must be entered on WiSACWIS and screened in or out by certain deadlines, depending upon the urgency of response required. The Child Protective Service Investigative Standards require that within the first 24 hours of receiving a report of maltreatment, the information must be analyzed to assess urgency for response. BMCW procedures require this decision to be made within four work hours, and some on an even tighter schedule. Referrals that are screened in are forwarded to Initial Assessment for further investigation. Referrals that are screened out require no further action from the Bureau, unless the referral involves an open family case that is currently assigned for services within the

Bureau. In such cases, the concerns outlined in the referral, although not a maltreatment issue, are reviewed and a follow-up plan developed by the assigned case manager.

Description of Review

Sample

There were two separate samples drawn for the Intake evaluation. The first consisted of the screened-in intakes from the 50 cases that were selected for inclusion in the Initial Assessment sample. All of these were cases where the Initial Assessment was completed after July 1, 2005. Although the majority of the intakes were recent, some were as much as nine months old at the time of the review.

A second sample consisting of ten screened-out referrals was also selected from the second quarter of 2005. These referrals were chosen individually and were not linked to referrals or cases in any other program. Reviews of both screened-in and screened-out intakes consisted solely of reviewing the information recorded in WiSACWIS along with any referral information that might have been located in the case file.

Participants

Since intake social workers and their supervisors handle hundreds of referrals every day and are rarely involved with any given referral for more than a day, no interviews with staff were conducted or requested.

Measurements

All intakes were rated on three areas:

- *Assessment of family situation* addresses how thorough intake was in receiving and recording information about the family and the alleged maltreatment, including interpreting and assessing information from persons who called Intake to make a report.
- *Decision making regarding maltreatment/ris*k addresses the appropriateness of the screening decision and whether intake correctly identified safety and risk factors.
- Additionally, all screened-in intakes and a few of those screened out were rated on response planning and facilitation, which concerns the response time assigned to the referral and the persons or entities notified of the allegation.

Findings

The ratings in the table below indicate mixed results in the scoring compared to last year. The Intake program scored .02 point lower than last year in the first area, .04 point lower in last category, but improved by .22 in the *decision making* area.

Table 1
Screened-in Intakes

2=Practice standards fully met
1=Practice standards minimally met
0=Practice standards not met

Measurement area	Score of 2	Score of 1	Score of 0	Average 2005	Average 2004	Average 2003
Assessment of family situation	38	11	1	1.74	1.76	1.8
Decision making regarding maltreatment/risk	45	4	1	1.88	1.64	--
Response planning and facilitation	45	4	1	1.88	1.92	1.82

Total intakes reviewed: 50

Strengths

For the majority of cases, the reviewers held that the information provided by intake staff was sufficient and that the justification for the screening decision and the response time was appropriate. Comments from reviewers include statements such as, "All areas of report are addressed to the extent known to reporter," "Children's ages taken into consideration for response time," and "Very clear why they made the decision to screen in."

Concerns

The explanations given for assigning scores of less than 2 for all areas are fairly consistent. Under *assessment of family situation,* three reviewers commented on the existence of prior referrals on the family. While the intake staff mentioned the existence of these referrals, it was not clear if they had been reviewed to obtain further information on the family or to provide a context for the current allegation. One of the low scores was due to recognizing that the fax report of the incident had more comprehensive information than the intake itself. Reviewers did not, however, identify situations where intake staff failed to recognize a prior referral or case on the family, as was found in 2003.

Under *decision making*, three reviewers noted that the reasons for the screening decision were unclear based on the information in WiSACWIS. Two others were not entered in a timely manner; one was screened in more than 24 hours after the referral, the other just over 51 hours. In one case the reviewer questioned the

appropriateness of assigning a 2-5 day response time, rather than a same-day response time.

Comparison of Intakes Received During "Normal Hours" versus "After Hours"

Eleven of the referrals reviewed were handled outside of regular business hours. Five were taken by after-hours CRT/After Hours staff who handle emergency referrals between the hours of midnight and 8:00 a.m. on weekdays, on weekends and holidays. Six were taken by the Crisis Response Team (CRT). CRT, a subunit of the Intake program, handles referrals received by the Bureau after normal business hours on weekdays, from 4:30 p.m. – 12:30 a.m. Their responsibilities are to prioritize referrals that arrive after business hours, assess them for urgency, and provide immediate intervention when the safety of a child is at risk.

The following chart compares the scores received by the two groups. The CRT/After Hours group received higher ratings than did the daytime Intake program in the area of *decision making regarding safety/risk* and in *response planning*, but slightly lower in assessment.

Table 2
Screened-in Intakes

2=Practice standards fully met
1=Practice standards minimally met
0=Practice standards not met

	Regular Hours					CRT/After Hours				
Measurement area	Score of 2	Score of 1	Score of 0	Average 2005	Average 2004	Score of 2	Score of 1	Score of 0	Average 2005	Average 2004
Assessment of family situation	30	8	1	1.74	1.39	9	2	0	1.72	1.60
Decision making-maltreatment/risk	34	4	1	1.84	1.53	11	0	0	2	1.90
Response planning and facilitation	34	4	1	1.84	1.93	11	0	0	2	1.9

Total Intakes reviewed: 50 Regular Hours: 39 CRT/After Hours: 11

The random sample included a substantial number of regular hour intakes versus small number of CRT/After Hours intakes, so comparing the two groups may not be justified. The chart suggests that the CRT and After-Hours programs are accomplishing their purpose by quickly making decisions that will impact child safety.

Screened-Out Intakes

Ten intakes that had been screened out during the third quarter were reviewed using the same instrument as the screened-in intakes. These cases were selected

at random and were not related to any other cases used during the review. A decision to screen out a referral does not reflect a belief that the incident being referred is false or insignificant. Some reasons that referrals might be screened out include: the incident is a licensing issue, as opposed to maltreatment; it is a police matter rather than a child protective services issue, or the referral describes information already reported to the Bureau. For some of these situations, intake would refer the concern to other parties, such as the current licensing or caseworker, or the police for follow up.

Table 3
Screened-out Intakes

2=Practice standards fully met
1=Practice standards minimally met
0=Practice standards not net

Measurement area	Score of 2	Score of 1	Score of 0	N/A	Average 2005	Average 2004	Average 2003
Assessment of family situation	9	1	0	0	1.9	1.8	1.6
Decision making regarding maltreatment/risk	10	0	0	0	2.0	1.7	--
Response planning and facilitation				10	*	1.67	1.6

* This review did not score this issue in 2005.
Total Intakes reviewed: 10

Nine of the ten intakes received no score lower than a 2 for *assessment of family situation.* All ten intakes received a score of 2 for *decision making regarding maltreatment/risk*. One case received a lower score in the *assessment* area only because the intake social worker failed to reference how a certain act of the parent would affect the child; however, there was no disagreement with the screening decision itself.

Comparison to 2004 Review

In response to the 2004 Comprehensive Review, the Intake program prepared a corrective action plan concerning the one recommendation in the 2003 Comprehensive Review.

To correct the identified issue of "Unclear documentation to explain screening decisions," intake staff developed codes for explaining the screening decisions.

- One set of codes is used for instances in which history has no bearing on the screen-in decision.
- Another set of codes is used for screen-out decisions.
- All of the codes were distributed for common use among the intake and initial assessment staff.

The reviewers saw an improvement in the documentation of reasons for screening. Intakes completed in the later part of the year included these codes, which provided a better explanation for the decisions made. There are, however, improvements to be made by intake social workers in the way they document the maltreatment and reasons surrounding the maltreatment. For example, there are still cases where documentation only identifies parental behavior without providing a description of how that behavior affects the alleged maltreatment of the child.

Another issue that reviewers commented on is the way history is recorded by intake social workers. It does not seem helpful to the intake service manager making a screening decision to only have past referrals listed. It would be more helpful to see the outcome of past referrals, i.e. screened-out, substantiated and the type of maltreatment documented in the intake report.

Recommendations to the Intake Program

1. This review supports the conclusion reached in 2003 and 2004 that the CRT program is valuable and should continue.
2. Clearer delineation should be documented in the intake regarding how the behaviors of the parents described in the report affects the maltreatment of their children.
3. Documentation of previous referrals should be evaluated to provide better information about the outcome of the referral and the types of maltreatment indicated.

Initial Assessment Program

Program Description

Initial Assessment (IA) is the program responsible for investigating referrals that are screened in by intake services. The IA social worker (IAW) is expected to investigate the allegations and make a determination of whether abuse or neglect occurred, assess and control for the safety of children, assess the family for service needs and document involvement with the parents, children, referral sources and collateral contact information. Supervisory oversight and consultation is required to ensure child safety and compliance with Bureau procedures and to facilitate completion of the investigation within 30 days. The IAW records the findings of the investigation on the Initial Assessment document in WiSACWIS. The initial assessment also contains documentation to support the finding on the allegation (whether it is substantiated or not), as well as the final decision regarding transfer to Safety Services, Ongoing Case Management, or case closure.

The Initial Assessment program is administered directly by BMCW. All IAWs and their supervisors, known as service managers, are State employees. Staff members are located at each of the five BMCW service sites, but are considered to be a single program. (BMCW transitioned from 5 sites to 3 service regions as of January 2006).

Description of Review

Sample

The sample for IA consisted of 50 cases, ten from each site, which were completed during the review period regardless of when the intake came in or when the investigation began. These cases were also those used for the reviews of screened-in intakes. No distinction or filtering was done to control for the length of time the cases remained open, to the finding of the investigation, or to program (if any) to which it was transferred.

Participants

The following information was derived from the interviews with case participants:

- The staff interviewed had eight months to 15 years of experience in child welfare. Only one staff member interviewed had less than one year of experience; the average was 6.5 years. They reported working for the Bureau of Milwaukee Child Welfare an average of 5 years.

- All of the investigators had at least a bachelor's degree in social work. Two possessed a Master of Social Work degree and one had a master's degree in a related field.
- Four staff members reported having investigated prior incidents with the family.
- Staff reported staffing the case with their supervisors on an average of three times during the life of the case. Four staff reported weekly supervisory consultations.
- Seventeen mothers, three fathers and three of the target children participated in interviews.

Even though family participation in the interviews was an essential element of this review, family members were not always available for the scheduled interviews. One site produced no family members for interviews. Site 4 had family participants for seven cases, and Site 5 had family interviews for six. Three fathers participated in this review, as opposed to none in previous years. Fewer initial assessment social workers (IAWs) participated in interviews than in past reviews. None of the sites had IAWs present for each case. At Site 5 an IAW was interviewed for only one of the ten cases.

Measurements

IA cases were given scores in up to seven areas:

- *Assessment of client need* included all members of the family;
- *Service planning and facilitation* pertained only to cases where IA recommended specific services or referral to social service agencies for the family and is not required in all circumstances;
- *Communication with the family* replaces *engagement of the family in case planning*, used in previous years. This change was made to reflect the need for IAWs to investigate sensitive allegations that made their involvement with the family one of communication rather than engagement. IAWs assignment to the family is brief because they are responsible for transferring cases to other programs within days of assignment;
- *Placement decision making* was applied to all cases and rated the decision to place a child in out-of-home care or to leave the child with the parent;
- *Investigation of allegation or circumstance*s refers to the thoroughness of the investigation itself;
- *Case transfer/closure/continuation* rated the decision to keep the case open, to close the case or to transfer it to another Bureau program;
- *Substantiation decision* was added this year to allow reviewers to comment on whether they believed that the decision about the finding was well-reasoned, well-explained and reasonable. Reviewers were

instructed to rate the finding on whether a reasonable person could have reached the same finding, not on whether they themselves would have come to the same conclusion.

Findings

The Initial Assessment program as a whole received lower scores in 2005 than in the review of 2004 in all areas. This occurred not just because there were fewer scores of 2 given, but because there were many more cases where scores of zero were given in one or more areas.

Table 4
Initial Assessment Scores

2=Practice standards fully met
1=Practice standards minimally met
0=Practice standards not met

Measurement area	Score of 2	Score of 1	Score of 0	Average 2005	Average 2004	Average 2003
Assessment of client needs	31	9	8	1.48	1.76	1.04
Service planning and facilitation	27	5	2	1.71	1.82	1.07
Communication with family	34	11	4	1.61	1.84*	0.92*
Placement decision making	41	6	2	1.80	1.88	1.40
Investigation of allegation or circumstances	34	13	3	1.62	1.76	--
Case transfer/closure/ continuation	40	6	4	1.72	1.8	1.56
Substantiation decision	41	6	3	1.76	--	--

*Reflects score from similar but different measure in past years.
Total Initial Assessment cases reviewed: 50

Strengths

IA showed strength in *placement decision making* which is the main safety indicator for the child. One reviewer's comments summarizes IA performance in this area, "(the) child's needs were addressed/recognized and upon meeting/talking to the parents, the best placement for the child was in the (parental) home."

The *service planning and facilitation* scores look at situations that either are referred to the Safety Services program or are closed with possible referrals to community agencies. Reviewer comments on closed cases include cases in which no safety or services needs were present or the family had no safety concerns, but refused services. Of the six cases that were referred to safety services, the reviewers found all but one had all services identified, and the one had the service requested added after consulting with the safety manager and family.

Regarding the *communication with family* section, the families interviewed generally related a favorable interaction with the IAW. One comment by a reviewer epitomizes the parents' statements, "Family reported worker was very engaging and did not make stressful situation worse."

Another area of strength for IA is *case transfer/closure/continuation*. Cases were transferred to either the Ongoing Case Management or the Safety Services programs or closed with BMCW as appropriate. Reviewers' comments included, "reasons clear and all safety factors addressed" and "appropriate based on investigation and info(rmation) provided," which illustrate the comprehensive job IA did with making closing or transfer decisions upon completing their assessments.

A new area of evaluation, *substantiation decision*, was first scored this year. IA received 41 of 50 possible scores of 2, which indicates 82% of these decisions were sound. A typical comment by reviewers was, "It is clearly documented re(garding) the decision making of the findings."

Concerns

The Initial Assessment program as a whole received lower scores in 2005 than in the review of 2004 in all areas. The overall lower average was because more scores of 1 were received, rather than because of averaging score of 2 and 0. The exception was the area of *assessment of client needs*, in which almost half the scores were zeroes.

For the second consecutive year, the area with the lowest average rating was *assessment of client needs*. Fathers were not part of at least five assessments. This was ascertained through the usual review of the documents and also by interviews with case participants. Two-thirds of the scoring in this category were 2s; one-third of all assessments were either poor or inadequate. In two cases, all of the allegations were not explored, and underlying causes were not mentioned in two other assessments. In one assessment, the physician of a pregnant teen was not consulted, and another case did not explore the vulnerability of a 14-year-old cognitively delayed girl who was sexually active.

In the *communication with family* section there is some progress with fathers being interviewed, but there were at least five cases in which the reviewers noted that fathers were not interviewed. A total of 18 family members were available to be interviewed for this review. For those cases in which the reviewers were not able to interview the family, the documentation was not clear as to whether or not the families understood the purpose of the assessment or if they were given information about their rights.

This was the first year the review separated the documentation about the gathering of information regarding the investigation versus the conclusion of the investigation. These two areas were separated to give a richer understanding of

these two distinct functions of IA – that of gathering of information about the allegation and the findings that follow from the investigation. The reviewers indicated that IA did a good job of documenting the reasons their decisions were made and using the documentation completed during the investigation to reach a determination. However, the reviewers found that almost one-third of the investigations were missing information that would be expected to be included in the documentation. The most common comment was that the investigation was peripheral to the allegation. One reviewer noted that the family "whooped" their children, but there was no mention of what "whooping" meant to that family. Information from other sources, such as physicians or police was also noted as lacking.

Comparison to 2004 Review

The majority of the recommendations from the 2004 review were suggestions from IAWs that would help with their job performance. BMCW identified several action steps associated with these requests and instituted a quality improvement plan in May 2005. Several of the action steps dealt with training of IAWs to better engage with the various families they encounter in the Child Protective Service field. The results are mixed. Family comments to the reviewers indicate IAWs fully explained the reasons they were talking with the families and that the families were listened to. However, IAWs were not always contacting fathers or incarcerated parents, or were not documenting why contacting parents was impossible given the circumstances.

Another set of action steps outlined obtaining collateral reports and the thoroughness of investigating all allegations to produce a more complete assessment of the findings and service needs of the family. More improvement is needed in this area.

Recommendations for the Initial Assessment Program

1. Create a method of assuring the complete assessment of family needs or document the rationale of why such an assessment is not necessary.
2. Document efforts to contact and interview fathers and incarcerated parents as part of the assessment or state the rationale of why such an assessment is not necessary.
3. Strengthen the documentation of information gathered in the investigation, including the use of collateral information.
4. Document the explanation the IAW gives to the parents of their rights and their understanding of these rights.
5. Service managers should document supervisory consultation and oversight in WiSACWIS.

Independent Investigation Program

Program Description

The Independent Investigation program investigates allegations of child maltreatment where there would be a real or perceived conflict of interest if the investigation were conducted by Bureau staff. The most common types of cases referred are those involving a Bureau employee, or those involving someone licensed by the Bureau (such as a foster parent). In Milwaukee County, all independent investigations are referred to a private contract agency for completion. Community Impact Programs (CIP) has been contracted to perform this function for BMCW since 2001.

CIP's role is to investigate the specific allegation and determine if the incident occurred, and whether the incident rises to the level of child maltreatment. CIP is not responsible for the initial determination of the children safety. This is completed by state employed initial assessment social workers within 24 hours of BMCW receiving the report of maltreatment. Initial Assessment staff determine whether the child is safe and will remain safe until the independent investigation is completed. Follow up to the referral, including implementing recommendations for services, foster parent training, licensure restrictions, or removal of children, are all the responsibility of other entities.

Description of Review

Sample

Twenty-five cases were reviewed where an independent investigation was completed during the third quarter of 2005. Twenty-three of these investigations involved foster homes licensed by Lutheran Social Services, the agency contracted by BMCW to license foster homes. One investigation involved a treatment foster home, and one involved a home licensed as an adoptive placement by Children's Service Society of Wisconsin (CSSW). Seven of the investigations resulted in a determination of substantiated maltreatment, 17 were unsubstantiated, and one bore a finding of "unlikely to occur."

Measurements

Because an independent investigation concentrates on the investigation of the allegation of maltreatment, CIP was only rated on two areas in this review – the quality of the *independent investigation* itself and the *substantiation decision*. As with the Initial Assessment program, the rating for the substantiation decision was a new addition in 2005.

The reviewers also provided ratings in a third area, *response to licensing/safety concerns*, which addressed how the licensing agency and ongoing case management responded to the results of the investigation. These ratings do not necessarily reflect on any one program, but are included to indicate how the Bureau as a whole is performing in response to these reports.

Participants

The evaluators interviewed the staff person who completed the investigation or his/her supervisor. Generally the alleged maltreator in these investigations was a foster parent. As part of the review, foster parents were invited to be interviewed. Nine foster parents agreed. Twenty-one licensing specialists or their supervisor who were assigned to the foster parent under investigation were also interviewed.

Findings

Table 5
Independent Investigation Scores

2=Practice standards fully met
1=Practice standards minimally met
0=Practice standards not met

Element/focus area	Score of 2	Score of 1	Score of 0	Average 2005	Average 2004
Independent investigation	24	0	1	1.92	1.96
Substantiation decision	25	0	0	2	--
Response to licensing/safety concerns	18	0	2	1.8	1.73*

*This score was from a similar element in the out-of-home care section of the 2004 review.
Total Independent Investigation assessments reviewed: 25

Strengths

Of the 25 investigations reviewed, 24 received a score of 2 for Independent Investigation. In the one case that did not meet this standard, reviewers noted that the investigator attempted, but did not succeed, in making contact with collateral sources of information, in particular medical personnel. (While contact with these sources would have enriched the assessment, they are unlikely to have had any bearing on the finding of the investigation.) In 11 of the 25 cases the reviewers specifically noted that all appropriate persons were interviewed.

Eight of the foster parents involved in these investigations cooperated with interviews for this review (up from five in 2004). All reported that the investigators asked for their version of the events, and all believed that they were listened to and treated respectfully. Two of the foster parents interviewed had been substantiated for maltreatment, and both reported that they were notified promptly of the investigation results and of their appeal rights.

Reviewers were very impressed overall with the quality and thoroughness of the investigations. At least one stated that the investigations could serve as a model to be emulated by the Initial Assessment program staff.

The evaluators also heard positive stories of the efforts to work with foster families. One reviewer wrote that Lutheran Social Services, the licensing agency, "worked long and hard with this foster family. (A) pattern of allegations led them to revoke the license only after lots of support was offered to them... This independent investigation was followed by more referrals and investigations. Court order kept the children in the home even after revocation." Another reviewer wrote about another case that the licensing worker "did a great job of supporting the foster parent and helped to prevent her from closing. She also advised (her) to try a new population (teen with baby) that appears to be a great fit. (She) went above and beyond with extra visits and support."

In the category of *substantiation decision* the reviewers found that the determination of maltreatment followed directly from the documentation and explanation provided by the CIP investigators.

Concerns

The way that investigations were documented made it difficult to determine when and in what order interviews and other activities took place. While this area has improved since it was noted in the 2004 Comprehensive Review, it remains a concern.

Other concerns raised during the case review related to other programs, rather than CIP. In one case there was a delay in assigning the case to a CIP investigator and a lack of communication between the different professionals involved with the case. In this one instance, the stress the foster parents experienced led them to ask for the removal of the child, who was subsequently placed in a far more restrictive treatment foster home placement.

In another case, the reviewers noted that the issue related less to the timing of the investigations but more to how the information about the investigation was communicated and processed by other programs. In this case, the ongoing case manager, who called in the referral, did so eight days after receiving the information that a child might be maltreated.

Again relating to another program, the reviewers found that the support plan for the foster parent did not appear to incorporate information recommended from the investigation.

Recommendations to the Independent Investigation Program

1. Continue to implement recommendations from the 2004 review regarding the clarity and thoroughness of documenting investigations.
2. The review indicates in a small group of cases that additional work needs to be done to communicate findings among the investigative agency, the licensing agency and ongoing case management, to ensure that follow up on the investigations is prompt and appropriate.
3. Revise format to make it easier to determine order of interviews and other activities.

Out-of-Home Care Program

Program Description

Out-of-Home Care is a service provided to ensure the safety of children when their safety cannot be ensured in their own home. The Out-of-Home Care (OHC) program performs centralized placement functions for the BMCW and is responsible for ensuring quality foster home placements for children referred by the Initial Assessment and Ongoing Case Management programs. OHC is also responsible for recruiting, training, and licensing a diverse pool of foster parents capable of caring for the special needs of children who cannot reside with their biological parents or guardians due to abuse or neglect. One of the primary functions of the OHC is to manage placement resources, identify, select and authorize the most appropriate out-of-home care placement, including foster homes, group homes, and residential care centers for BMCW children. OHC staff, known as licensing specialists, are responsible for conducting thorough assessments of prospective foster parents, ensuring that licenses are renewed on a timely basis, assisting with problems in foster placements, matching children with out-of-home care providers, monitoring the care foster parents provide to children, following up on licensing and safety concerns, and providing support to out-of-home care providers. OHC staff, known as placement specialists, are responsible for identifying available placement providers, determining which provider is best suited to meet the particular needs of the child, checking on capacity of the selected resource, and maintaining contact with the child's social worker and providing the social worker with placement information.

Description of Review

For the 2005 Comprehensive Review, a decision was made to focus on one particular aspect of the program's functions that had not been thoroughly reviewed in the past. This is the placement and matching function. As part of the 2002 Settlement Agreement of the Jeanine B. lawsuit, the Bureau agreed to discontinue the use of shelters and to replace them with the following options:

- **Assessment Family Homes**, operated by specially trained foster care providers, are designed to meet the immediate first-time placement needs of children age birth through 11. Assessment home providers are expected to not only provide safe, nurturing and enriching care for children, they are also expected to observe children's needs and characteristics in order to contribute to subsequent placement decisions.
- **Adolescent Assessment Centers and Placement Stabilization Centers** provide a short-term placement for adolescents ages 12-17. These centers are intended to provide a safe and nurturing living environment in which adolescents can be stabilized, supervised, and assessed for the most appropriate permanent placement.

  The Adolescent Assessment Centers are for first time placement of adolescents between the ages of 12 and 17 entering out-of-home care.

  Placement Stabilization Centers accept placements of behaviorally, emotionally and/or socially challenged adolescents who require stabilization after a disruption in their placement. Placement Stabilization Centers may also accept first time placements if the adolescent has challenging behaviors.

Prior reviews of the Out-of-Home Care Program have focused on the licensing process and on the quality of support plans, and on efforts made to stabilize and support placements. During 2005, there have been concerns raised about the number of moves children in out-of-home care were experiencing and the length of time youth and children were spending in assessment centers for adolescents, assessment homes and placement stabilization centers. The decision was made to focus the current review on these facilities, on efforts made to stabilize previous placements (when applicable) and on how assessments for future placements were being made.

Sample

Twenty-seven cases were selected for review. These included nine children who had been in placement stabilization centers, nine in assessment homes and nine in assessment centers.

Participants

Interviews were conducted with OHC placement and licensing staff, adolescent assessment and placement stabilization center staff, ongoing case managers, foster parents and youth.

Measurements

Cases were reviewed on the following areas:

- *Assessment of provider needs and abilities* addresses the effort to comprehensively assess and determine the provider's skill level and ability, including strengths and weaknesses.
- *Foster parent support plan/ongoing training* addresses efforts to provide a plan specific to the foster parent and the foster children placed in the home and efforts to include services or supports to help the foster parent(s) meet the child's needs.
- *Placement stability* addresses the attempts made to stabilize the placement and provide or offer appropriate services and supports.
- *Quality of assessment of child's needs* addresses the quality of assessment provided by the assessment home, assessment center or placement stabilization center, including the reasons for the child's disruption for the previous placement, when applicable, identified mental health, physical or behavioral characteristics, as well as child's maturity level and interpersonal characteristics.
- *Decisions regarding placement and matching* addressed the efforts to locate the most appropriate placement for the child and how the assessment of the child's needs was used to select a placement.
- *Response to licensing/safety concerns* addresses efforts and action to investigate concerns and make appropriate intervention.

For those cases where the child was removed from a placement before spending time in the facility, these ratings were given for both placements (the placement prior to the center placement and the subsequent placement).

Findings

Table 6
Out-of-Home Care Scores

2=Practice standards fully met
1=Practice standards minimally met
0=Practice standards not met

Measurement area	Score of 2	Score of 1	Score of 0	Average 2005	Average 2004	Average 2003
Assessment of provider needs and abilities – prior placements*	2	5	1	1.13	1.6	--
Foster Parent Support Plan/ongoing training – prior placement*	2	4	3	.89	1.5	.68
Placement stability- prior placement*	2	6	4	.83	1.66	1.16
Quality of assessment of child needs	5	13	7	.92		
Assessment of provider needs and abilities – new placements*	7	2	6	1.07		
Foster parent support plan/ongoing training – new placements*	7	3	1	1.55	1.5	.68
Decisions regarding placement and matching -new placement	6	9	4	1.11	1.7	(1.30)
Placement stability – new placement*	9	4	4	1.3	1.66	1.16
Response to licensing/safety concerns	4	1	1	1.5	1.73	--

* Scores for these areas in prior years were not divided between new and old placements.

● For cases where items were not applicable, the averages were calculated using the total number of applicable scores.

● The table does not include scoring specific to assessment homes, except in *quality of assessment of child needs.*

Strengths

Of the cases reviewed for which there was a foster home placement, more than 80% (9 of 11) had either a new support plan or an existing support plan updated during the review period as required. It is important to note that the focus of this review was on cases for which there was a stay in an assessment center, assessment home, or placement stabilization center. The scores may not be indicative of all licensing specialist work in foster homes. In 60% (6 of 10) of the

cases, the reviewers' comments indicated that these support plans were individualized to the child and foster parent or reflected actual events in the family.

There is evidence that assessment homes are well supported. Eight of the nine assessment home providers cooperated with interviews during the review and reviewers reported that all comments relating to the support provided by the licensing specialists and assessment home coordinator were positive. One reviewer noted, the "assessment coordinator is in constant contact with provider to work through needs of both child and foster mother." A provider reported that "The coordinator is always available and responsive."

Another area of strength relates to the reports from five teens who had been placed in an assessment or stabilization center and who participated in interviews for this review. All five responded that they felt safe in these centers. Three teens also reported that the center staff are "nice" and "they care." It was also reported that disagreements between residents were handled fairly.

Concerns

Scores of zero were given for four cases in the area of support plans for children in homes prior to their placement in assessment homes or placement stabilization centers. Three support plans were not up to date and one case had no support plan at all. In at least 10 cases, the reviewers commented that the support plans were generic or unspecific. While there was improvement in support plans provided for the more recent placements, this is an area that will require ongoing attention in the Out-of-Home Care program

Lack of foster home resources for adolescents is another area of concern as reviewers noted that efforts to match children to foster homes were limited by the lack of foster home resources. For the 11 cases reviewed in which a foster home placement was made, there were eight cases with only one foster home option provided and three cases with two options provided by the placement specialist. There was only one case in which three foster home options were provided. Placement specialists reported that they initially focused efforts on finding an available foster home bed for the age and gender of the child, rather than the specific needs of the child. Once an empty bed was identified, the assigned licensing specialist was provided with a brief description of the child and asked to determine whether or not the placement was a good match. In three cases, the reviewers noted that documentation included notes referring to a need to find a placement quickly because the child's length of stay exceeded the time limit. For eight of the 17children with a placement in a center, the length of stay exceeded the maximum time limit.

In another area of the review, 17 cases included an interview with the licensing specialist assigned to the foster home. Although a recommendation was made in

2004 for licensing specialists to have regular contact with the children in foster homes in order to provide the foster parent with the proper level and type of support, 15 of the 17 licensing specialists reported having little or no contact with the child, either due to the child's school schedule, the limited amount of time that the child was placed in the home or to the time that the worker had been assigned to the case. One licensing specialist responded that she "supervises the home rather than the children."

Another area of concern relates to children placed in group home beds as an alternative to an adolescent assessment or placement stabilization center. Due to fluctuations in the number of children coming into care, and the number of children disrupting from placements, it is not possible to have assessment and placement stabilization center beds available for peak times. The OHC has established agreements with a number of group home facilities where children may be placed when all center beds are filled. The group home facilities ensure that children referred for assessment and placement stabilization are provided services similar to those provided at the centers. There is concern, however, as two teens interviewed, who had been placed in such facilities, reported inconsistencies related to the care and treatment provided. Both teens reported that they were not provided with an orientation or tour of the facility and one teen reported that food was withheld as punishment.

Use of Assessment/Stabilization Centers

Adolescent assessment and placement stabilization centers exist to provide a short-term placement for adolescents ages 12-17. The Adolescent Assessment centers are for first time placement of adolescents entering out-of-home care. The placement stabilization centers accept placements of behaviorally, emotionally and/or socially challenged adolescents, who require stabilization after a disruption in their placement. It was noted during the review, that children are inappropriately placed in both types of centers. Three adolescents, who had been in previous licensed placements, were placed in assessment centers, and three children, who were new to the system, were placed in placement stabilization centers.

Length of stay issues in the centers also surfaced in this review. For the cases reviewed, the median length of stay for children placed in assessment centers was 40 days, and 40.5 days in placement stabilization centers, as compared to a median of seven days for children placed in assessment homes. This is problematic given that center stays are restricted to 20 days for children with a post-dispositional legal status. Reviewers questioned the ability of the centers, working in collaboration with the OCM, to complete an adequate assessment and provide stabilization within 20 days, especially for teens with run away issues and for teens who indicate by words and/or actions a reluctance to be placed in a foster home.

Value and Use of Assessments

There are concerns related to the quality of the assessments provided by the assessment and placement stabilization centers, and the assessment homes. Assessment center providers received the lowest scores related to quality of assessments, averaging .38, while assessment homes received an average score of 1.0, and placement stabilization centers received an average score of 1.33. Reviewers noted that the assessments generally included adequate descriptions of day-to-day behaviors and events, but did not incorporate information about the child's strengths, the underlying causes of the child's difficulties, and often did not indicate that an individual interview was done with the child.

Reviewers also noted concerns related to the process for obtaining the assessment from assessment family homes. The process seems to limit the information and the quality of the assessment. The assessment home coordinator, or a placement specialist from the OHC, calls the provider to obtain information that is transferred to an assessment form. This is a verbal transaction and the assessment home provider does not submit a written assessment of the child. Two reviewers noted that the assessment information seemed to focus more on problems and negative characteristics, rather than the child's strengths. One assessment home provider stated that she "didn't go deep regarding the assessment of child's needs and behaviors because she didn't think that LSS wanted that information."

Efforts at Matching

Reviewers noted that the efforts to match by the placement specialists seemed limited by the lack of foster home resources for adolescents. While there was evidence of some direct contact between OHC staff and ongoing case managers to share information and assess the viability of the match, it was also evident that the benefit is limited due to the limited number foster home resources. Reviewers noted that only one foster home option was provided in eight of the cases reviewed, and two options were provided in three cases. There was only one case in which three options were provided, but it was noted that this child was ultimately approved for higher level of care and placed in a treatment foster home.

While the average score for *decisions regarding placement and matching* dropped from 1.7 in 2004 to 1.19 in 2005, it is important to note that the average includes three cases for which the matching and placement was completed by the OCM and no referral was made to the OHC. In these cases, ongoing case management was responsible for matching the child to a kinship placement. Of the four cases receiving a score of zero, three were for kinship placements made by an OCM. One reviewer noted that the "the OCM seems to have given up on this child and placed with a relative without much regard to appropriateness of placement."

Efforts at Stabilization

This item was separated into two areas relating to the placement stability of prior placements (prior to the child's assessment or stabilization center stay) and placement stability for the subsequent placement. The average "prior placement" score is .83 and the average "new placement" score is 1.3. The difference between the two scores may be related to the implementation of newly established requirements for joint visits to foster homes by assigned licensing specialists and ongoing case managers within five days of placement. The "five-day stabilization meeting" was put in place in May, 2005. One reviewer noted "licensing specialist and OCM have completed one joint home visit and have another scheduled next week. Crisis plan is comprehensive and specific to child."

There is indication of need for support and stabilization efforts in kinship placements by the ongoing case management staff. For the three cases reviewed in which there was a kinship placement made, all three reviewers reported that there was no evidence of any action or effort to support the placement, even though there was indication of instability in two of the cases. For the cases reviewed in which there was a foster home placement made, it is interesting to note that all 11 children remain in that placement as of the writing of this report. Two of the three kinship placements have disrupted and two of the five reunifications were not successful. All children placed in group homes (2), treatment foster homes (2), residential treatment centers (1), and pre-adoptive homes (1) remain in those placements as of the writing of this report.

Comparison to 2004

The review of the Out-of-Home Care program was redesigned for 2005 to focus on the placement and matching function; therefore no comparison to 2004 can be made.

Recommendations to the Out-of-Home Care Program

1. Individualize Support Plans for each foster home specific to the children placed in the home. This recommendation was made in the 2003 and 2004 Comprehensive Reviews.

2. OHC licensing specialists should be familiar with the children placed in the foster home by reviewing the child's file and attending Coordinated Service Team (CST) meetings.

3. The assessment tool used by the centers needs to incorporate more information regarding placement recommendations and the child's opinion regarding placement. The tool used by the placement stabilization centers should be revised to include information regarding

the reason for and/or underlying causes of the child's placement disruption. Additionally, center staff responsible for completing assessments and assessment home providers should be provided with specific training related to providing quality assessments.

4. Develop a process to obtain quality assessment information from assessment family home providers.

5. Attention is needed to appropriate placement of children in the adolescent assessment and placement stabilization centers based on the specific purpose of each type of center. Children who are new to out-of-home care should be placed in assessment centers and children needing stabilization should be placed in placement stabilization centers.

6. Additional foster home resources are needed to address the unique developmental, emotional and cultural needs of adolescents requiring an out-of-home placement. In addition, more placement options beyond foster families are needed for adolescents when a family setting is not the best fit for a particular child.

Ongoing Case Management Program

Program Description

Ongoing Case Management responsibilities include providing services and supervision to children who have been removed from their parents and placed in out-of-home care, working with birth parents to achieve child safety, permanency and well-being, or who remain with their parents under court supervision. Ongoing Case Managers (OCMs) are responsible for a variety of activities for children in the legal custody of the BMCW, including monitoring child safety and actively managing cases to obtain permanency for children through reunification, adoption, or a permanent relative placement. As the principal coordinators of care for children, they are also responsible for a child's well-being by monitoring his or her educational, physical and mental health needs, and ensuring that needed services are provided for children, parents, and caregivers. OCMs retain primary responsibility for making decisions about child placement and recommend any changes in the child's permanency goal, including recommendations to pursue adoption, to the Children's Court. Ongoing Case Management currently retains primary assignment to these cases until:

- the child returns home and the court order is dismissed,

- the parental rights of the child are terminated and the case is transferred to adoption,
- the child is placed with a guardian and the court-order is dismissed, or
- the child "ages out" of the system without achieving permanency.

Description of Review

Sample

In 2005, there were two agencies providing Ongoing Case Management services at the five service sites in Milwaukee: Children's Family and Community Partnerships, Inc. (CFCP) at Sites 1, 2, 3 and 5; and La Causa at Site 4.

Ten cases were reviewed from each site, for a total of 50 cases. One child per case was identified in advance as being the focus of the review. In the 50 cases reviewed, the children's ages were between newborn to 17 years-of-age. Forty-seven percent were under 11 years-of-age and 53% were 12 years and older. The age breakdown was as follows:

6 were 0-4 years,
17 were 5-11,
15 were 12-15, and
11 were 16 or older.

Children had been placed in out-of-home care was between 1 and 17 years. The breakdown of time in care is as follows:

- 38 had been in care for one year or more. Of those:
  - 15 children (39%) were in their current placement less than one year, and
  - 23 children (61%) were in their current placement one year or more.
- 12 children entered out-of- home care in 2005,
- 9 children had been in out-of-home care for 1 year,
- 5 children have been in out-of-home care for 2 years,
- 4 children have been in out-of-home care for 3 years, and
- 20 children have been in out-of-hone care for 4 years or more.

Fifteen children in the sample (30%) had only one placement during their current episode in out-of home care

Review Participants

Interviews were completed with 45 ongoing case managers as part of the review. In 24 cases, one or both parents participated in interviews; this included 23

mothers and 2 fathers. Two legal guardians were also interviewed. Eight children, 29 foster parents and 37 service providers participated in interviews.

Measurements

Cases in Ongoing Case Management were rated on the following areas:

- *Assessment of client needs* included the needs of the child and the parent.
- *Decision making around service planning and selection*.
- *Actions taken to facilitate service provision.*
- *Actions taken to engage the family in service.,*
- *Decision making regarding placement.*
- *Actions taken to identify/locate appropriate placement.*
- *Actions taken to maintain contact with collaterals.*
- *Actions taken to ensure the stability of foster placements.*
- *Decision making regarding permanency planning and direction of case.*
- *Actions taken to ensure that visitation occurs* included visits with biological siblings as well as parents.
- *Case closure/transfer/continuation.*

It should be noted that the scoring in each area results from the record review and the verification of information from the individual interviews.

Findings

Table 7

Ongoing Case Management Scores
Bureau-wide

2=Practice standards fully met
1=Practice standards minimally met
0=Practice standards not met

Measurement Area	Score of 2	Score of 1	Score of 0	Average 2005	Average 2004	Average 2003
Assessment of client needs	32	18	0	1.64	1.61	1.32
Decision making around service planning and selection	38	11	0	1.78	1.66	--
Actions taken to facilitate service provision	36	11	2	1.69	1.64	--
Actions taken to engage family in services	35	15	0	1.70	1.49	1.34
Decision making regarding placement	40	7	1	1.81	1.76	--
Actions taken to identify/locate appropriate placement	39	7	1	1.81	1.79	--
Actions taken to maintain contact with service providers and collaterals	41	9	0	1.82	1.63	1.14
Actions taken to ensure stability of foster placements	33	15	0	1.69	1.51	1.36
Decision making regarding permanency planning and direction of case	33	14	3	1.60	1.57	1.66
Actions taken to ensure that visitation occurs	26	13	3	1.55	1.70	1.54
Case transfer/closure/ continuation	40	10	0	1.80	1.73	1.84

Total ongoing cases reviewed: 50.
Note: Some cases have areas that are not applicable, so not all columns will equal 50.

Strengths

In 2005, there was a demonstrated improvement in the following measures:

- *Decision making around service planning and selection.,*
- *Actions taken to engage family in services.*
- *Actions taken to maintain contact with service providers and collaterals.*
- *Actions taken to ensure stability of foster placements.*

In other areas improvements made in 2004 were sustained, including:

- *Assessment of client needs,*
- *Actions taken to facilitate service provision,*
- *Decision making regarding placement,*
- *Actions taken to identify/locate appropriate placement,*
- *Decision making regarding permanency planning, and*
- *Direction of case and case transfer/closure/continuation.*

Concerns

In one area, *actions taken to ensure that visitation occur*s, there is a decrease in the average score compared to 2004. This is one area where the improvements gained in 2004 were not sustained in 2005. In 2004, 54 of 72 applicable cases (76%) the OCM had arranged visits to parents and siblings on a regular basis. In 2005, 26 of 50 cases (52%) of the OCM arranged regular visits between parents and siblings.

In 16 of the 50 cases (32%) where the practice standards were not met documentation indicated there was lack of a formal visitation plan, there were lapses between visits, structured visits were not indicated, or visits were left to relative caregivers and older siblings to schedule between parents and siblings.

Comparison of Site Performance

There were some noticeable differences between the sites in terms of their performance on different measures. These results are summarized in table 8.

Table 8

2=Practice standards fully met
1=Practice standards minimally net
0=Practice standards not met

Measurement areas	Site1	Site 2	Site 3	Site 4	Site 5
Assessment of client needs	1.50	1.60	1.50	1.70	1.90
Decision making around service planning and selection	1.67	1.90	1.70	1.90	1.70
Actions taken to facilitate service provision	1.56	1.90	1.80	1.80	1.40
Actions taken to engage family in services	1.90	1.60	1.60	1.70	1.70
Decision making regarding placement	1.60	2.00	1.90	1.70	1.89
Actions taken to identify/locate/secure appropriate placement	1.50	1.89	1.80	2.00	1.88
Actions taken to maintain contact with service providers and collaterals	1.80	1.80	1.90	2.00	1.60
Actions taken to ensure stability of foster placements	1.60	1.90	1.67	1.78	1.50
Decision making regarding permanency planning and direction of case	1.60	1.60	1.60	1.70	1.50
Actions taken to ensure that visitation occurs	1.89	1.70	1.29	1.25	1.50
Case transfer/closure/ continuation	1.90	1.90	1.90	1.50	1.80

Although no one site or agency out-performed the others in all areas, the data in Table 8 indicate wide ranges of scores across measurements and noticeable differences or variations in outcomes between sites. Greater detail will be provided on specific performance in the sections below.

Assessment of Clients Needs and Service Provision

Strengths

The improvements gained in 2004 were sustained in 2005. There was a slight improvement in the number of OCM who achieved minimal compliance with practice standards. In a majority of the cases 32 of 50 (64%) of the OCM demonstrated attentiveness to the clients and collaborated with service providers in re-evaluating service needs regarding efficacy and appropriateness.
There was significant improvement compared to 2004 in the following areas:

- *decision making around service planning and selection,*
- *actions taken to facilitate service provision, and*
- *actions taken to maintain contact with service providers and collaterals.*

In the majority of cases services were appropriately identified in 38 of 50 (76%) cases and consistently re-evaluated for efficacy and appropriateness. In addition, OCM aggressively pursued service in 36 of 50 cases (72%), especially medical and dental services for children and follow up with providers to obtain progress information in 41of 50 cases (82%).

Concerns

In the cases where practice standards were largely unmet, the review indicated that:

- OCMs did not assess the parents' own ability or access to services,
- did not re-assess or evaluate services when new developments occurred or feedback from service providers indicated that services were not effective, or
- relied only on client self-reports regarding compliance with services.

Also noted were delays in setting up new services when a change in services was warranted.

Engagement of family in Services

Strengths

In 35 of the 50 cases reviewed (70%), the OCM was consistent in efforts to initiate and engage parents and children in services. Parents were active participants in case planning and permanency goals were discussed and explained to parents and caregivers, especially relative caregivers. Many OCMs accommodated the parent's work or treatment schedules when scheduling services.

Concerns

In 15 of the 50 (30%) cases it was indicated that the OCMs were inconsistent in engagement activities, especially with biological fathers, paternal caregivers and adolescents. In the majority of cases 36 of 47 cases (77%) services were identified and implemented for mothers. That was not the case for fathers, where only 7 cases of the 40 (18%) had services identified and implemented. In addition, parents who were incarcerated were less likely to be linked to services. There were 2 mothers and 5 fathers who were incarcerated during the review period only 1 mother and 1 father were receiving services while in incarcerated.

Placement Decisions and Stabilization

Strengths

Overall there has been improvement in the areas of *placement decision making and placement stabilization*. Of the 50 cases reviewed, 40 (80%) OCMs met practice standards regarding *placement decision making* compared the 57 of 75 (76%) cases reviewed in 2004. In 39 of the 50 cases (78%), it was indicated that placement decisions and OCM action taken to identify appropriate placements were based on the child's needs and caregiver strengths. This was an 11% improvement over 2004 in activities taken to ensure stability of foster placements. Of the 50 cases reviewed in 2005, 33 (66%) met practice standards compared to 41 of 75 (55%) cases reviewed in 2004.

Placement decisions generally included discussion with parents, caregivers and licensing staff. Placement changes appeared to be thought through and planned in order to meet the treatment needs and safety of the child when the caregiver could no longer meet the child's needs. Higher level of care placement, such as in treatment foster care, group homes and residential care centers, were well documented.

Concerns

Concerns regarding cases where practice standards were not met include lack of information provided to caregivers regarding the child's needs at the time of placements and collaboration (joint decision making) with parents and caregivers, especially relative placements, regarding placement changes. In addition, documentation lacked justification for placement changes and decision making process. Respite care needs did not seem to be addressed or were minimized, especially with children placed with relatives. There was limited documented contact with the treatment foster care staff and little, if any, documentation regarding joint home visits with general licensing staff.

Decisions Making Regarding Permanency Planning and Direction of Case

In 2004, there was a decline in the average scores in the area of *decision making regarding permanency planning* and *direction of case* compared to 2003. The following recommendation was made in 2004:

> *The Ongoing Case Management agencies should outline specific steps to ensure that all OCMs and their supervisors fully understand their responsibilities and their abilities to pursue permanency for children. This understanding must go beyond recognizing the time frames of ASFA.*

As a result, BMCW implemented changes including requiring adoption staff to participate in the Coordinated Service Team (CST) process, publication of BMCW policy regarding CST meetings, advanced training in CST facilitation and mandatory filing of a Termination of Parental Rights petition at 12 months.

Strengths

In 2005, there were moderate gains in this area, and on average, a six percent increase in the number of OCMs who fully met practice standards. In 2005, 33 of 50 cases (66%) reviewed scored a 2 compared to 45 (60%) in 2004.) In the majority of cases, the OCM used the CST meetings and permanency plan review process to discuss and plan for the permanency needs of the child. The largest gains in this area were the number of cases that scored a 1. In 2005, 14 (28%) received a score of 1 compared to 28 (37%) in 2004. However, any gains should be weighed against the 6% increase in the number of OCM who failed to meet the practice standard or ignored critical elements. (In 2005, 3(6%) scored 0 compared to 2 (3%) in 2004.

Concerns

The following concerns remain as first noted in 2003 and again in 2004.

The 2005 review showed that, as in 2004, CST's are occurring: 39 of the 50 (78%) cases a CST was scheduled and completed on time during the review process, 11 cases were not scheduled or completed on time. However, the review indicates that CSTs are not always conducted according to the model the Bureau has adopted. There were instances permanency was clearly not the focus of the CST. As a result, there were cases where:

- ASFA compliance was perceived as permanency:
- there were long delays in addressing barriers to permanency for the child:
- inappropriate placements were made without consideration of the permanency needs of the child, and
- services were put in place that may have stabilized the out-of-home placement but failed to address permanency.

Moreover, AODA providers and Wraparound Milwaukee conduct their own CST meetings that may not address all the service and permanency needs of parents and children, but rather focus on their specific client. This was true in one case where the AODA provider advocated reunification based only on the sobriety of the parent and failed to consider the history of domestic violence, mother's lack of mental health treatment, cognitive impairments and the continued contact by the maltreator with the children. None of the service providers for the children or caregivers were invited to the AODA or Wraparound Milwaukee CST.

Several reviewers reported interviewing families who did not know what a CST was and did not immediately recognize the concept, but who did remember attending a staffing with different people. Some knew that they were able to help determine who would be invited to these meetings, but others did not. Several foster parents reported that they did not receive the required written notification of

the meetings. Age appropriate adolescents and children are not regularly invited to or participated in CST meetings. Some CST's, in fact, appear to have been held rather spontaneously. Some were not documented on WiSACWIS until after the interviewers inquired about them. (The review period was specifically arranged so that at least one CST would have taken place.)

Although Adoption program staff participate in CST's, especially in new cases entering out-of-home care, the OCM did not collaborate regularly with Adoption staff when the permanency plan changed in older cases where a child is in out-of-home care two years or more, and may have resulted in delays in achieving timely permanency. This was especially noticeable when there was concurrent planning. Approximately, 18 (36%) of the cases reviewed had a concurrent plan. Of those, six had a concurrent goal of adoption, either as the primary goal or secondary goal; even though in 29 of the cases (58%) reviewed, the child had been in out-of home care two years or more.

It does not appear that concurrent planning is understood or used appropriately. In one case, the OCM had assigned three permanency goals; reunification, termination of parental rights (TPR) and transfer of guardianship (TOG), with the OCM indicating that all three are in the child's best interest. The OCM was not actively pursuing any one particular course of action. In another case, the adoption staff member was recently assigned to the case, although the child had been in out-of home care four years and had a concurrent goal that included adoption. Adding or subtracting a permanency plan goal appears arbitrary. In one case, the OCM indicated that the court had added adoption as a concurrent goal, but there is no justification documented for the change, nor was the family aware that adoption had been added.

In 2005, as in the 2003 and 2004 Comprehensive Review, there were cases identified where reunification remained the principal, if not sole, permanency goal even though return of the children was unrealistic based on the parents' prior behaviors and inability to benefit from services. In other reunification cases, there was little information regarding the actual planning for reunification.

The Bureau's expectation is that improvement will continue in all areas where less than full compliance with standards has been found.

Recommendations to Ongoing Case Management

1. Develop and implement specific strategies to engage biological fathers and paternal relatives early on in the case.

2. Develop and implement visitation plans and ensure that they are updated and consistently maintained.

3. Evaluate the use of concurrent planning and ensure that strategies are identified to move the case forward.

4. Develop and implement specific strategies to ensure adoption staff participation in the CST process in cases where the child has been in OHC for two or more years and the permanency plan changes to TPR and adoption.

5. Develop and implement placement stabilization plans for kinship care providers.

Safety Services

Program Description

The Safety Services program works with families to maintain children safely in their homes whenever possible and appropriate, and to ensure that families have enhanced capacity to provide for their children's needs. The Safety Services program provides short-term services to families who have been reported for child abuse or neglect. The program works to manage immediate safety factors within the home. Families are referred to the Safety Services program from Initial Assessment if it is determined that the children can safely remain in the parents' home with appropriate services and if the parents are able and willing to cooperate in keeping the children safe. Safety service managers are required to meet with families at least weekly and also have weekly contact with service providers.

These guidelines are in place to ensure that children can safely remain in their own homes and to reduce the risk of repeat maltreatment, to enhance the ability of families to care for their children, and to maintain family relationships which might otherwise be disrupted if the children were to be placed in out-of-home care.

Description of Review

Samples

Two agencies provided safety services during the review period: Children's Family and Community Partnerships (CFCP) at Sites 1, 2 and 3, and La Causa at Sites 4 and 5. Twenty-five cases open in safety services at any point during the third quarter of 2005 were reviewed. The sample consisted of five cases per site.

Participants

Participants interviewed were parents, safety service workers, parent aides, a life skills provider, and a therapist.

Measurements

Cases in safety were scored according to the following measures:

- *assessment of client needs* including both the parents or guardian and the children;
- *decision making around service planning and selection;*
- *actions taken to facilitate service provision* including efforts to enroll clients in service;
- *attention to safety issues;*

- *actions taken to engage family in services;*
- *decision-making regarding safety* that addressed planning in response to identified safety issues;
- *actions taken to maintain contact with service providers and collaterals,* and
- *case transfer/closure/ continuation.*

Scores in each area are a result of both the review of case documents and the interviews with case participants.

Findings

Table 9
Safety Services Scores

2=Practice standards fully met
1=Practice standards minimally met
0=Practice standards not met

Measurement area	Score of 2	Score of 1	Score of 0	Average 2005	Average 2004	Average 2003
Assessment of client needs	13	10	2	1.44	1.68	1.14
Decision making around service planning and selection	19	6	0	1.76	1.76	--
Actions taken to facilitate service provision	19	5	1	1.72	1.80	--
Attention to safety issues	19	5	1	1.72	1.84	1.36
Actions taken to engage family in services	18	6	1	1.68	1.64	.98
Decision-making regarding safety	19	5	1	1.72	1.76	--
Actions taken to ensure child safety	18	6	0	1.75	1.92	--
Actions taken to maintain contact with service providers and collaterals	19	5	1	1.72	1.72	1.12
Case transfer/closure/ continuation	15	10	0	1.60	1.68	1.16

Total Safety Services cases reviewed: 50

Strengths

Services were maintained even though there was a decline in the scores pertaining to *assessment of client need*s and *actions taken to facilitate service provision.* There was evidence that safety case managers were concentrating on safety of the children. Case file documentation indicates that staff were checking the children and the household for signs of neglect or abuse. This was found both during the worker's involvement and as cases were preparing for closure.

Overall, the documentation in Safety Service cases was clear and complete. In particular, reviewers frequently noted clear explanations for closing cases, documentation of efforts to contact service providers and continue services when

necessary. There were several instances where cases remained open due to ongoing issues within the home.

In two cases, closure did not occur because of anticipated child births and the need to make appropriate transition of services. Documentation also suggests that when continued services were needed, the family was reportedly referred to community providers, such as a parenting resource center and Narcotics Anonymous.

Interviews were conducted with 18 families. A majority of the families reported that they felt the program was voluntary, although four reportedly felt pressured or threatened with having their children removed. Family members described their safety service workers using terms such as "professional," "excellent" and "willing to provide support." There was an instance where the safety service manager was described as "wonderful, however, if you want to improve what workers do, you need to lower the number of limitations on them because the limitations do not allow workers do what needs to be done."

Parents who participated in interviews were very complimentary of their workers for the amount of involvement and services they were receiving. One child's mother stated that the safety service worker "helped out a lot." Another said that her worker "is good and very supportive."

Concerns

A major concern was with the Coordinated Service Team (CST) process, and how families reported that it was not thoroughly explained to them. Of the 25 family cases reviewed, 17 families were able to be interviewed. Of the 17, nine interviewees were either unsure about what CSTs were or if they ever attended any. Conversely, eight interviewees answered affirmatively that they knew about CSTs. In one of the family cases reviewed, no CST was reportedly done since the initial family meeting. Based upon the family interviews completed during case reviews, it appears that clear distinctions are not made between CST meetings and weekly meetings families have with the safety services case manager.

Five of the ten scores of 1 in Safety Services were for planning regarding case closure. In one case, the client's W-2 services were ending due to the W-2 agency closing, thus leaving the family without financial support in addition to losing safety services support. In two examples cases closed without services directed to fathers within the home. There were also two cases that remained open for prolonged periods due to a breakdown in the implementation of services, such as assisting a family in getting their electricity turned back on after it had been disconnected for six weeks and failure to address unresolved family issues in a timely manner.

Comparing the scores of the two agencies involved produces the following results:

Table 10

Safety Services Scores by Agency

2=Practice standards fully met
1=Practice standards minimally met
0=Practice standards not met

Measurement area	Average – Bureau - wide	Average CFCP	Average La Causa
Assessment of client needs	1.44	1.46	1.40
Decision making around service planning and selection	1.76	1.73	1.80
Actions taken to facilitate service provision	1.72	1.6	1.90
Attention to safety issues	1.72	1.73	1.70
Actions taken to engage family in services	1.68	1.6	1.80
Decision-making regarding safety	1.72	1.67	1.80
Actions taken to ensure child safety	1.75	1.79	1.70
Actions taken to maintain contact with service providers and collaterals	1.72	1.67	1.80
Case transfer/closure/continuation	1.60	1.53	1.70

Of the nine measures, La Causa had higher averages in six of the measures, and CFCP had higher averages in three of the measures. The three cases in the sample receiving scores of 0 in any of the areas were CFCP cases. Site 3 received all scores of 2 for seven different areas, Site 5 for four, and Site 4 for one. Sites 1 and 2 did not receive scores of 2 in any areas.

Assessment of Needs

Prior comprehensive reviews have consistently identified key areas that safety service workers failed to address. These were issues of substance abuse, domestic violence, and mental health. This continues to appear in the 2005 review. Out of 25 safety cases reviewed, two received scores of 0 and ten received scores of 1. The lack of assessment and assistance for parents with chemical dependence issues were cited. In one particular case, the overall effects of drug abuse and its impact on the family unit was not fully addressed. (The father was addicted to prescription drugs, which affected his ability to maintain employment in order to sustain a household.) There was a documented occurrence where an assessment failed to indicate what type of impact that an alleged father, with a substantial history of domestic violence and sexual assault convictions, could have on determining the future safety needs within the home environment. In this case, the alleged father could pose a threat of physical harm to children living in the home. Case reviews also documented a mother's mental health issues that were not thoroughly assessed, as well as the father's domestic violence issues. These were all safety issues because of the child being vulnerable within the home.

Documentation in another case indicated domestic violence issues that were identified but not added to the service plan.

Concerns remain about assessing mental health and domestic issues. In a particular case documentation showed that the mental health and behavioral issues of all family members were not thoroughly assessed. In addition, reports indicate that no assessments occurred for children within a home where wrist cutting and fire starting were taking place. The case reviewers concluded that the safety service manager may have minimized the behaviors, due to the lack of assessments and no documented effort to involve the family in discussions about these concerns. Case notes in this situation also indicate that the safety service manager denied payment for therapy and switched the family to insurance covered therapy. The reviewers noted, "The action seems more related to the agency not wanting to pay for services than wanting to offer a service that is effective."

Quality assessments were also identified that reflected efforts made by safety service managers to identify family needs. Examples include cases where it was noted that "Very good analysis of children and family needs" occurred, "Safety service managers took every opportunity to identify ongoing needs by talking with the mother, family members and professional support systems," and "At first the assessment was basic, but as the rapport developed, more of the underlying dynamics were revealed by parent."

Decision Making Around Service Planning and Selection

The planning in response to identified safety issues consisted of clients not being informed about their service planning or not having input into the process. Based on case findings, it could not be determined that safety service managers were aware of specific provider issues. As indicated in the case file poor documentation, as well as insufficient communication between the safety service manager and provider led to the provider dropping a client due to her missing appointments. Apparently the safety service manager was unaware of the client's poor attendance. Reviewers raised concerns when the lack of communication attributed to poor service facilitation and in, at least one case, there was "no contact with mental health provider, minimal contact with AODA provider, no coordination or facilitation of communication between providers."

Service Provision

Reviewers raised concerns where an agency did not provide required emergency services for families. One of the most compelling involved a family that had been without electricity for several weeks at the time of the review. The Safety Service agency was aware of their situation, but denied payment to the family to restore power. This was of special concern because an infant and pregnant teenager were

residing in the home. It was noted by reviewers that candles were used at night, which posed safety issues. In another case, a family without a refrigerator or stove was unable to obtain a free one they had located on their own, because they were unable to find a truck to transport it, and the agency was unable to help. The common theme in many of these situations was not that the safety service agency partner was faced with needs for obscure or difficult-to-locate services for which they were unprepared, but that the Safety Services program contract agency felt that the type of assistance the family needed was not their responsibility.

Another theme that repeatedly was raised had to do with the family's involvement with the Wisconsin Works or W-2 program. This review is not intended to review that program, but it is worth noting that many families and workers interviewed expressed frustrations with the system. Their concerns ranged from difficulty contacting the workers to a perception that workers would not help families unless they had an advocate, such as a safety service case manager, who knew what questions to ask and how to work with the system.

Recommendations for Safety Services Program

1. Agencies should reevaluate their efforts to ensure that all family members, in particular biological fathers, are involved in assessment and service planning.

2. Safety Service providers should include success indicators in their service plans and clearly communicate to families the conditions that should be met for the case to be considered ready for closure.

3. Agencies should ensure that case managers possess the knowledge and comfort level in dealing with complicated and sensitive issues, such as domestic violence, substance abuse, and mental health concerns.

4. Before a case closes, safety service staff should assist families in making connections with community resources.

Adoption

Program Description

The Adoption program for Milwaukee County serves to achieve permanency for children through three principal functions. The program provides:

- case management for children whose parents' rights have been terminated by the Children's Court;
- recruitment and licensing of adoptive families, and
- consultation with birth families, ongoing staff, foster parents and others about permanency, adoption and adoption related issues.

Children's Service Society of Wisconsin, under contract with the Bureau of Milwaukee County Welfare (BMCW), has the responsibility to provide centralized adoption services for the BMCW.

Once termination of parental rights (TPR) is achieved, Children's Service Society of Wisconsin (CSSW) assumes full responsibility for facilitating and achieving permanency for these children by identifying and supporting families who are able to care for them, through adoption, until they reach adulthood.

Description of Review

Sample

The case sample consisted of 25 cases that were open for services with a primary staff person assignment in Ongoing Case Management and a secondary staff assignment to an adoption worker with CSSW. Efforts were made to ensure that each child's case reviewed had an adoption worker rather than a permanency consultant. This would allow the reviewers to examine the work of the adoption program prior to the finalization of a TPR order. The requirements of the adoption program at this point are consultation with the family and the ongoing case manager; matching and placement if the current caregivers are not to be considered as an adoptive resource, and assessment of the current caregivers if they wish to be considered for adoption.

Participants

Interviews were conducted with adoption staff, ongoing case managers, and licensed foster parents.

Measurements

Four areas were identified for examination:

- *Interaction with prospective adoptive resource*, including efforts by the adoption program to assess the family for licensure and to advise them of the requirements for adoption.
- *Efforts to facilitate placement and matching* by the adoption program. This area was scored when the adoptive resource was not the child's current foster care placement.
- *Efforts to move toward permanency* including efforts by the Adoption program to take a proactive role in achieving permanency for the child and to utilize other resources when appropriate.
- *Collaboration with ongoing case management and out-of-home car*, including efforts by the adoption program to communicate and collaborate with other professionals involved in the case.

Findings

Table 11
Adoption Scores

2=Practice standards fully met
1=Practice standards minimally met
0=Practice standards not met

Measurement area	Score of 2	Score of 1	Score of 0	Average 2005	Average 2004	Average 2003
*Interaction with prospective adoptive family	20	2	1	1.83	1.6*	--
Efforts to facilitate placement and matching	10	3	0	1.77	1.3	2.00
Efforts to move toward permanency	17	6	1	1.67	1.5	--
Collaboration with OCM and OHC	15	5	4	1.46	--	--

*The corresponding measure in 2004 was *assessment of adoptive resource.*
For cases where items were not applicable, the averages were calculated using the total number of applicable scores.
Total adoption cases reviewed: 25

Interaction with Prospective Adoptive Family

Of the 23 cases reviewed for this focus area, 20 cases received a score of 2. Two cases received a score of 1, and one case received a score of 0. For the cases that received a score of 2, it was demonstrated that thorough home studies had been completed, including good assessments of the children. The adoption staff were noted to be actively engaged with the adoptive family, as well as other key individuals involved with the case, and that the adoptive family believed the

adoption staff to be supportive and responsive of any needs or concerns they may have had. Open and meaningful communication was acknowledged by staff and adoptive family members. In several instances, adoption staff had backup plans in place should the need arise. The following quote, taken from one of the cases, is a characterization of the cases reviewed in this area: "Excellent case planning-very well managed case-communication is flowing between caregiver, OCM, and adoption worker. Caregiver is familiar with child prior to placement in his home based on the fact that the caregiver has two of the child's siblings since October 2004," and "All parties have participated in CST's, including caregivers, therapist and adoption staff. Services and needs of the children and caregiver are documented and addressed."

With the cases that scored below 2, the prominent issues were around poor documentation and lack of follow through by adoption staff to coordinate requests with OCM for services. In one case reviewed, a need regarding a caregiver had been identified, however, there was no information found that supportive services had been offered or implemented. In another case, the family requested anger management services for the child they plan to adopt, but there was no documented follow up by the assigned adoption staff and there were limited efforts by adoption staff to be proactive or to problem solve when faced with a possible disruption of placement. Also noted in one case, was poor effort with respect to the timely initiation of the home study. The home study process had just begun at the time of this review, although referral to the program was made in October 2004, and the child had been placed with the prospective adoptive family in May 2005. The explanation for the delay was that the child expressed hesitation about being adopted. There is no evidence to suggest that the staff had addressed the child's concerns. The family expressed frustration with service implementation and with moving forward with the home study process because they believed the staff had not been responsive to their questions, concerns, requests and needs.

Efforts to Facilitate Placement and Matching

Of the 13 cases reviewed for this focus area, ten cases received a score of 2 and three cases received a score of 1. No case received a score of 0.

In the cases where the standard was fully met, it was determined that adoption staff had taken many factors into consideration regarding finding appropriate caregivers for the children they were responsible for. The unique needs of a child and a family's ability to provide for those needs led to individualized and targeted recruitment efforts. Placing children with siblings in an adoptive family appeared to be valued and was pursued in a number of the cases. Many of those efforts were successful as appropriate caregivers were found.

Regarding one of the three cases that received a score of 1, the reviewers noted that unexpected behavioral problems surfaced with the child resulting in the

adoption process being put on hold. Services were put in place for the child, however, there was no evidence of services to support the family and to help them understand the child's needs and how best to address them. Even though it appeared the placement might disrupt, the adoption worker reported that "no other adoptive resources are being explored." In another case, the adoption staff was not actively recruiting for an adoptive placement even though there was indication that reunification might not occur.

Efforts to Move toward Permanency

Of the 24 cases reviewed in this area, 17 cases received a score of 2. Six cases received a score of 1, and one case received a score of 0.

Cases that fully met the standard in this area demonstrated a clear plan for permanency. The adoption staff appeared to be knowledgeable about the plan and there was indication that the plan had been discussed with the family in 20 of the cases reviewed. In 11 of the cases reviewed, there was indication that the court process was progressing according to schedule and/or the date for the adoption finalization hearing had been set.

For the six cases receiving a score of 1, there were a number of concerns identified. In one case, there was a lack of communication and agreement between the adoption staff and the OCM as to the appropriate permanency plan. Adoption had not been discussed with the family, and both workers seemed to be waiting for the Court to determine the direction. Two adoption workers reported confusion regarding the permanency plan. For example, one case has a "triple plan for permanency". The plan is described as including reunification, long-term foster care, and TPR/adoption. The reviewer reports that, "Everyone involved is confused about the perm plan." There was no indication that the adoption worker was attempting to get the problem clarified or resolved. In another case, the worker reported that the case was held up in Court, but there was no indication of any proactive effort to resolve the problem. She also reported that she has minimal communication with the OCM and obtains the majority of information from reading case notes.

For the case that received the 0 score, the reviewers noted that there was no clear reason why the TPR had not occurred. The documentation indicated that the mother had not been involved in the case for a 5-year period. There were, however, numerous changes in OCMs and it appeared that the adoption process was started over several times.

Collaboration with Ongoing and Out-of-home Care

Twenty-four cases were reviewed for this focus area. Fifteen cases received a score of 2; five cases scored 1, and four cases scored 0.

For cases receiving a score of 2, there was indication of ongoing communication between the adoption worker and the OCM. Fifteen adoption workers reported that they had attended a recent CST meeting and all 15 reported positive interaction and collaboration with the OCM.

Of the cases receiving a score of less than 2, there was little evidence of meaningful communication and minimal effort to collaborate with the OCM or out-of-home care worker by the adoption staff. In two cases, the adoption worker had never been invited to a CST meeting, and in one case, the adoption worker did not know the date of the TPR hearing. In another case, the adoptive resource reported confusion related to receiving conflicting information from the adoption worker and OCM.

Strengths

Collaboration with Ongoing Case Management and Out-of-Home Care programs had not been reviewed previously, however, the score received for this review is encouraging with 15 of 24 cases (63%) fully meeting the practice standards. Adoption staff appeared to be more involved with ongoing case managers, out-of-home care staff, family members and service providers related to a case when compared to previous review years.

Efforts to facilitate placement and matching showed strong improvement over last year, with ten of 13 cases (77%) fully meeting the practice standards. Efforts to match children to special and unique needs with qualified, able, prospective adoptive families were particularly successful in five cases. The assessments of homes and children were thorough and timely. Communication between adoption staff and caregivers also improved when compared to past reviews. Attendance at CST meetings increased this year, although improvement is still needed.

Thirteen of 17 (76%) caregivers interviewed, reported that adoption staff are available to them and supportive of their needs. Nineteen of 24 adoption staff (79%) report feeling supported by their supervisors, that supervisors are helpful to them in working with families and meet with them regularly to discuss cases.

Concerns

Documentation across all areas of the program continues to be of concern. Another concern is that in some cases, adoption staff appear to miss opportunities to serve as advocates for children and families and to be proactive when challenges occur in a case. Examples include one case in which the referral to the adoption program was made in March, but the adoption worker made no effort to meet with the caregiver or start the home study until November. In another case, the caregiver's ability to adequately care for the child is questioned, but the reviewer reported minimal effort by adoption staff to address the concerns or provide the caregiver with needed assistance.

Life Books are not being completed for children who are in the process of adoption, even though this is required by contract with the adoption agency. In two cases, there was indication that the materials had been given to the adoptive resource to complete. One reviewer noted that "Life Books were left with the adoptive resource, but no direction was provided and the provider is confused about how to put the book together and overwhelmed with the task."

Recommendations for the Adoption Program

1. Ensure that all adoption staff are sufficiently trained to accurately document their interactions with children and families, other staff, service providers, and the court system. Documentation in all areas of casework should be in accordance with contract requirements; and should be specific, informative, descriptive and meaningful.

2. The agency should ensure that workers are able to identify potential barriers to permanency, and that they have the authority, support and resources to advocate for children and families should a barrier become known.

3. Ensure that adoption staff is interacting regularly and in a meaningful way with other staff and service providers involved with the case. CST meetings should be attended regularly and used as a tool for achieving the best possible outcomes for children.

4. Strengthen quality and frequency of contact with children to prepare them for adoption and allow for better assessment of their needs.

5. Prepare Life Books for every child being adopted. Train staff as needed on the purpose, content and importance of Life Books for children who are adopted.

Conclusions and Final Recommendations

The BMCW and its partner agencies have developed the framework for best practice in child welfare. This partnership recognizes that the strengths or practical concerns in one program can impact all others. Improvements have been made across all program areas. It is recommended, however, that all programs continue to focus on the following identified areas where practice needs to be strengthened across all child welfare program areas:

- Strengthen meaningful engagement with biological parents, children, out-of home caregivers, and between child welfare professionals involved with the child. Specific collaborative strategies are needed to engage biological fathers, incarcerated parents, and relative caregivers in realistic decision making on placement and permanency planning for their children.
- Provide greater clarification to biological families, foster parents and service providers and their role as team members in implementing the CST process.
- Conduct and use assessments that contain comprehensive and descriptive information. The information should include: child safety, development, physical and mental health status, and the underlying causes of maltreatment, as well as the capacity, functioning and needs of parents, and the ability of out-of home caregivers to care for the child.
- Improve timely information sharing and communication across program areas that is critical to the success of a coordinated child welfare system.
- Maintain frequent, consistent and quality interactions with children by child welfare professionals as a necessary component to a quality assessment and reinforce as a standard of child welfare practice.
- Plan and implement visitation between children, their parents and siblings, and evaluate the impact on the stability of out-of-home placement and achieving timely permanence.
- Develop and implement individualized support and service plans that match the identified needs of the child, parent and caregiver. Improve coordination and communication within and between programs and service providers (private and public) regarding consistency and timeliness of support and services.
- Strengthen and improve timely and descriptive documentation regarding problem solving, contacts with parents, caretakers and service providers about needed services, placement decisions, permanency plans and outcomes.

- Give attention to improving documentation by supervisors about their oversight and direction of case activities.
- Improve quality of case management provided to Kinship families caring for children in out-of-home care, and to foster parents; to ensure child safety and placement stability.
- Identify realistic permanency options and appropriately use concurrent permanency planning, especially in cases where the child has been in out-of-home care for more than 24 months.
- Collaborate on strategies to address the overall lack of foster homes, specifically for adolescents, and the impact on all programs when a child is placed in an out-home-care home or center and their needs are not met.
- Develop and conduct cross program training as a collaboration between BMCW and its contract agency partners, including the University of Wisconsin (UW-M) Training Partnership, for all child welfare supervisors regarding a coordinated response to children and families through:
  - comprehensive and integrated assessments,
  - placement decisions that ensure the safety and permanency of children,
  - realistic and timely permanency planning,
  - development of strategies associated with concurrent permanency planning,
  - training of child welfare supervisors from all programs together not as an individual unit,
  - inclusion of out-of home caregivers, kinship providers and assessment and placement stabilization center staff in cross training,
  - incorporating case studies indicating best practice into training.

- Strengthen the relationship between programs, network service providers, and community resources, in order to ensure timely and coordinated service delivery.

Overall, program areas demonstrated consistency in their efforts to address concerns noted in prior comprehensive reviews. As indicated in the current report, each program area demonstrated improvements and sustained performance since 2003. In areas where programs fell short of their 2004 performance, it is recommended that all programs will be as diligent as they have been in developing and implementing targeted strategies to address performance concerns identified in the 2005 review.